

**Hoag Cancer Institute**

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**FAMILY HISTORY QUESTIONNAIRE**

An accurate family history is very important in the process of assessing the risk of hereditary cancer in your family. Please read and follow these instructions carefully, as correct completion of this form will speed processing and provide more accurate risk assessment. If you are not certain about a cancer diagnosis for some of your relatives, take the time to make phone calls to get complete information. It is not uncommon for family members to have had cancer, but not discuss it. Obtain medical records (e.g. pathology reports) if possible.

Please contact us at [hereditarycancer@hoag.org](mailto:hereditarycancer@hoag.org) or (949) 764-5764, if you have questions. Thank you!

Your Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Your referring physician's name: \_\_\_\_\_

What is your ethnicity?  White  African American  Hispanic  Asian  Other: \_\_\_\_\_

Ancestry (Example: England, Germany, Russia, Ireland, Italy, etc.)

My mother's ancestors are from: \_\_\_\_\_

My father's ancestors are from: \_\_\_\_\_

Are you of Ashkenazi (Eastern/Central European Jewish) descent?  Yes  No  Don't know

Check here if anyone in your family has had genetic testing for hereditary cancer.

Check here if a mutation in a hereditary cancer gene (e.g. *BRCA1*, *BRCA2*, *MLH1*, *MEN1*, etc.) has already been identified in your family. **Important: Please provide a copy of your relative's test results prior to your appointment.**

On the following pages, enter all family members requested by the form, **including those who do not have a cancer diagnosis**, as well as those who do have cancer.

There is one blank page at the end where you can include any additional information.

**FAMILY HISTORY QUESTIONNAIRE**

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## FAMILY HISTORY QUESTIONNAIRE

Please tell us about your family history. **More accurate risk assessment can be made with complete information.** You may need to contact family members to be sure of getting accurate information. **Please fill in all relatives, regardless of whether or not they have had cancer.**

First Name (optional)	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps?  Yes/No	COMMENTS
				Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis		
You:	Yes								
Your Mother: <i>NAME:</i>									
Mother's Mother: <i>NAME:</i>									
Mother's Father: <i>NAME:</i>									
Your Father: <i>NAME:</i>									
Father's Mother: <i>NAME:</i>									
Father's Father: <i>NAME:</i>									

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### YOUR BROTHERS AND SISTERS

Please include only sisters and brothers who are related by blood. For brothers and sisters who are half-siblings, write in which parent you share (e.g. half sister through mother)

First Name (optional)	Sex M/F	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps? Yes/No	COMMENTS
					Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis		

## YOUR CHILDREN

First Name (optional)	Sex M/F	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps?  Yes/No	COMMENTS
					Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis		

### RELATIVES ON YOUR MOTHER'S SIDE

If there are more than 6 siblings, please write them in on the last page.

First Name (optional)	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps?  Yes/No	COMMENTS
				Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis		
Mother's sister:									
Mother's sister:									
Mother's sister:									
Mother's brother:									
Mother's brother:									
Mother's brother:									

Do you have any first cousins on your mother's side with cancer:  Yes  No  Don't know      If yes, please list below.

First Name (optional)	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis	Son/Daughter of

### RELATIVES ON YOUR FATHER'S SIDE

If there are more than 6 siblings, please write them in on the last page.

First Name (optional)	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps?  Yes/No	COMMENTS
				Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis		
Father's sister:									
Father's sister:									
Father's sister:									
Father's brother:									
Father's brother:									
Father's brother:									

Do you have any first cousins on your father's side with cancer:  Yes  No  Don't know If yes, please list below.

First Name (optional)	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis	Son/Daughter of

### OTHER RELATIVES

Please include any other relatives you think we should know about. Be specific about how this person is related to you, e.g. *mother's father's sister*.

First Name (optional)	HOW IS THIS PERSON RELATED TO YOU?	Sex Male/ Female	Living Yes/No	Current Age (if living) or Age at Death (if deceased)	Cancer Diagnosis Yes/No	FIRST CANCER		OTHER CANCER		10 or more colon polyps Yes/No
						Location or Type	Age at Diagnosis	Location or Type	Age at Diagnosis	

Please include any additional information here: